RI MEDICAL ASSISTANCE PROGRAM
PRIOR AUTHORIZATION REQUEST FORM
FAX OR MAIL TO:
RI PA CALL CENTER
145 Technology Lane ▪ Henderson, NC 27537
FAX # 1-800-390-0109

REQUEST FOR PRIOR AUTHORIZATION FOR A NON-PREFERRED DRUG

DATE:_____

CLIENT NAME: _____ DOB:_____ MEDICAID ID NUMBER:_____

PRESCRIBER NAME: _____PRESCRIBER NPI/DEA #:_____

PRESCRIBER OFFICE ADDRESS: _____

OFFICE PHONE NUMBER : ( )_____

REQUESTER NAME: _____ RN/MD/RPH:_____

PHONE NUMBER: ( )_____ FAX NUMBER: ( )_____

DRUG REQUESTED: _____QTY / FILL: _____

DIAGNOSIS, ICD-9 CODE:_____

PDL MEDICATIONS IN THE **SAME CLASS** THAT THE PATIENT HAS TRIED: _____

WHAT WAS THE OUTCOME? _____

IF YOU ARE REQUESTING A BRAND NAME DRUG, PROVIDE THE DATES THAT THE GENERIC WAS TRIED AND THE OUTCOME:
_____

_____

EXPLAIN WHY THIS PARTICULAR NON PDL MEDICATION IS MEDICALLY NEEDED FOR THIS PATIENT:

_____

_____

PRESCRIBER SIGNATURE _____ **DATE** _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

RI PRIOR AUTHORIZATION CALL CENTER PHONE NUMBER 1-866-420-3874, HOURS M-F, 9 AM-6 PM (EST)

PA # _____ **APPROVED**_____ **DENIED** _____ **PENDING ADDITIONAL INFORMATION**_____

DATE /TIME OF RECEIPT _____ **DATE/TIME RESPONSE** _____ **REVIEWER** _____

COMMENTS:

Revised 05.20.08